

Notice of Intent to Provide Public Access Defibrillation

Original Notification ☐ Update ☐

Entity Providing PAD

Name of Organization	() Telephone Number	
Name of Primary Contact Person	E-Mail Address	
Address	() Fax Number	
City	State	Zip

Type of Entity (please check the appropriate boxes)

<input type="checkbox"/> Business	<input type="checkbox"/> Fire Department/District	<input type="checkbox"/> Private School
<input type="checkbox"/> Construction Company	<input type="checkbox"/> Police Department	<input type="checkbox"/> College/University
<input type="checkbox"/> Health Club/ Gym	<input type="checkbox"/> Local Municipal Government	<input type="checkbox"/> Physician's Office
<input type="checkbox"/> Recreational Facility	<input type="checkbox"/> County Government	<input type="checkbox"/> Dental Office or Clinic
<input type="checkbox"/> Industrial Setting	<input type="checkbox"/> State Government	<input type="checkbox"/> Adult Care Facility
<input type="checkbox"/> Retail Setting	<input type="checkbox"/> Public Utilities	<input type="checkbox"/> Mental Health Office or Clinic
<input type="checkbox"/> Transportation Hub	<input type="checkbox"/> Public School K – 6	<input type="checkbox"/> Other Medical Facility (specify)
<input type="checkbox"/> Restaurant	<input type="checkbox"/> Public School 6 - 12	<input type="checkbox"/> Other (specify)

PAD Training Program

<input type="checkbox"/> American Heart Association	<input type="checkbox"/> National Safety Council	<input type="checkbox"/> REMSCO of NYC, Inc
<input type="checkbox"/> American Red Cross	<input type="checkbox"/> Emergency Services Institute	<input type="checkbox"/> EMS Safety Service, Inc
<input type="checkbox"/> American Safety & Health Institute	<input type="checkbox"/> Medic First Aid International	<input type="checkbox"/> State University of NY

Automated External Defibrillator

Manufacturer of AED Unit	Model of AED Pediatric Capable <input type="checkbox"/>	Number of Trained PAD Providers	Number of AEDs
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Emergency Health Care Provider

Name of Emergency Health Care Provider (Hospital or Physician)	Telephone Number	
Address	() Fax Number	
City	State	Zip

Name of Ambulance Service and 911 Dispatch Center

Name of Ambulance Service and Contact Person	Telephone Number
Name of 911 Dispatch Center and Contact Person	County

Authorization Names and Signatures

CEO or Designee (Please print)	Signature	Date
Physician or Hospital Representative (Please print)	Signature	Date